CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amendment)

907 KAR 10:014. Outpatient hospital service coverage provisions and requirements[~~services~~].

RELATES TO: KRS 205.520, 42 C.F.R. 447.53

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.6310, 205.8453

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520 empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes the Medicaid program service and coverage policies for outpatient hospital services[~~provisions relating to outpatient hospital services for which payment shall be made by the medical assistance program on behalf of the categorically needy and medically needy~~].

Section 1. Definitions. (1) "Current procedural terminology code" or "CPT code" means a code used for reporting procedures and services performed my medical practitioners and published annually by the American Medical Association in Current

Procedural Terminology.

(2)[~~"Comprehensive choices" means a benefit plan for an individual who:~~

~~(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. A nursing facility in accordance with 907 KAR 1:022;~~

~~2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;~~

~~3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160;~~

~~4. The Model Waiver II Program in accordance with 907 KAR 1:595;~~

~~5. The Acquired Brain Injury Long Term Care Waiver Program in accordance with 907 KAR 3:210; or~~

~~6. The Michelle P. Waiver Program in accordance with 907 KAR 1:835; and~~

~~(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.~~

~~(2)~~] "Department" means the Department for Medicaid Services or its designee.

(3) "Emergency" means that a condition or situation requires an emergency service pursuant to 42 C.F.R. 447.53.

(4) "Emergency medical condition" is defined by 42 U.S.C. 1395dd(e)(1).

(5) “Enrollee” means a recipient who is enrolled with a managed care organization.

[~~"Family choices" means a benefit plan for an individual who:~~

~~(a) Is covered pursuant to:~~

~~1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;~~

~~2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);~~

~~3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);~~

~~4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);~~

~~5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or~~

~~6. 42 C.F.R. 457.310; and~~

~~(b) Has a designated package code of 2, 3, 4, or 5.~~]

(6) "Federal financial participation" is defined by 42 C.F.R. 400.203.[~~"Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:~~

~~(a) Caretaker relatives who:~~

~~1. Receive K-TAP and are deprived due to death, incapacity, or absence;~~

~~2. Do not receive K-TAP and are deprived due to death, incapacity, or absence; or~~

~~3. Do not receive K-TAP and are deprived due to unemployment;~~

~~(b) Individuals aged sixty-five (65) and over who receive SSI and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~

~~2. Receive SSP and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(c) Blind individuals who receive SSI and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~

~~2. SSP, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(d) Disabled individuals who receive SSI and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or~~

~~2. SSP, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;~~

~~(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022; or~~

~~(h) Pregnant women.~~]

(7) "Lock-in recipient" means a recipient enrolled in the department's lock-in program pursuant to 907 KAR 1:677.

(8) "Medical necessity" or "medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53.

(10) “Provider” is defined by KRS 205.8451(7).[~~"Optimum choices" means a benefit plan for an individual who:~~

~~(a) Meets the intermediate care facility for individuals with mental retardation or a developmental disability patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. An intermediate care facility for individuals with mental retardation or a developmental disability patient status criteria established in 907 KAR 1:022; or~~

~~2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and~~

~~(c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.~~]

(11) "Recipient" is defined by KRS 205.8451(9).

(12) "Unlisted procedure or service" means a procedure:

(a) For which there is not a specific CPT code; and

(b) Which is billed using a CPT code designated for reporting unlisted procedures or services.

Section 2. Coverage Criteria. (1) To be covered by the department:

(a) The following [~~services~~]shall be prior authorized and meet the requirements established in paragraph (b) of this subsection:

1. Magnetic resonance imaging[~~ (MRI)~~];

2. Magnetic resonance angiogram[~~ (MRA)~~];

3. Magnetic resonance spectroscopy;

4. Positron emission tomography[~~ (PET)~~];

5. Cineradiography/videoradiography;

6. Xeroradiography;

7. Ultrasound subsequent to second obstetric ultrasound;

8. Myocardial imaging;

9. Cardiac blood pool imaging;

10. Radiopharmaceutical procedures;

11. Gastric restrictive surgery or gastric bypass surgery;

12. A procedure that is commonly performed for cosmetic purposes;

13. A surgical procedure that requires completion of a federal consent form; or

14. An unlisted procedure or service; and

(b) An outpatient hospital service, including those identified in paragraph (a) of this subsection, shall be:

1.a. Medically necessary; and

b.[~~2.~~] Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and

2.[~~3.~~] For a lock-in recipient:

a. Provided by the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or

b. A screening or emergency service that meets the requirements of subsection (6)(a) of this section[~~subsection~~].

(2) The prior authorization requirements established in subsection (1) of this section shall not apply to:

(a) An emergency service;

(b) A radiology procedure if the recipient has a cancer or transplant diagnosis code; or

(c) A service provided to a recipient in an observation bed.

(3) A referring physician, a physician who wishes to provide a given service, or an

advanced practice registered nurse may request prior authorization from the department.

(4) The following covered hospital outpatient services shall be furnished by or under the supervision of a duly licensed physician, or if applicable, a duly-licensed dentist:

(a) A diagnostic service ordered by a physician;

(b) A therapeutic service, except for occupational therapy services as occupational therapy services shall not be covered under this administrative regulation, ordered by a physician;

(c) An emergency room service provided in an emergency situation as determined by a physician; or

(d) A drug, biological, or injection administered in the outpatient hospital setting.

(5) A covered hospital outpatient service for maternity care may be provided by:

(a) An advanced practice registered nurse [~~(APRN)~~] who has been designated by the Kentucky Board of Nursing as a nurse midwife; or

(b) A registered nurse who holds a valid and effective permit to practice nurse midwifery issued by the Cabinet for Health and Family Services.

(6) The department shall cover:

(a) A screening of a lock-in recipient to determine if the lock-in recipient has an emergency medical condition; or

(b) An emergency service to a lock-in recipient if the department determines that the lock-in recipient had an emergency medical condition when the service was provided.

Section 3. Hospital Outpatient Services Not Covered by the Department. The following services shall not be considered a covered hospital outpatient service:

(1) An item or service that does not meet the requirements established in Section 2(1) of this administrative regulation;

(2) A service for which:

(a) An individual has no obligation to pay; and

(b) No other person has a legal obligation to pay;

(3) A medical supply or appliance, unless it is incidental to the performance of a procedure or service in the hospital outpatient department and included in the rate of payment established by the Medical Assistance Program for hospital outpatient services;

(4) A drug, biological, or injection purchased by or dispensed to a recipient[~~patient~~];

(5) A routine physical examination; [~~or~~]

(6) A nonemergency service, other than a screening in accordance with Section 2(6)(a) of this administrative regulation, provided to a lock-in recipient:

1. In an emergency department of a hospital; or

2. If provided by a hospital that is not the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or

(7) Occupational therapy services.

Section 4. Therapy Limits. (1) Speech pathology services[~~therapy~~] shall be limited to twenty (20) service[~~:~~

~~(a) Ten (10)~~] visits per calendar year per[~~twelve (12) months for a~~] recipient[~~ of the Global Choices benefit package; or~~

~~(b) Thirty (30) visits per twelve (12) months for a recipient of the:~~

~~1. Comprehensive Choices benefit package; or~~

~~2. Optimum Choices benefit package~~].

(2) Physical therapy services shall be limited to twenty (20) service[~~:~~

~~(a) Fifteen (15)~~] visits per calendar year per[~~twelve (12) months for a~~] recipient [~~of the Global Choices benefit package; or~~

~~(b) Thirty (30) visits per twelve (12) months for a recipient of the:~~

~~1. Comprehensive Choices benefit package; or~~

~~2. Optimum Choices benefit package~~].

(3) A service in excess of the limits established in subsection (1) and (2) of this section shall be exceeded if the service in excess of the limits are determined to be medically necessary by the:

(a) Department if the recipient is not enrolled with a managed care organization; or

(b) Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.[~~The therapy limits established in subsections (1) and (2) of this section shall be over-ridden if the department determines that additional visits beyond the limit are medically necessary.~~

~~(a) To request an override:~~

~~1. The provider shall telephone or fax the request to the department; and~~

~~2. The department shall review the request in accordance with the provisions of 907 KAR 3:130 and notify the provider of its decision.~~

~~(b) An appeal of a denial regarding a requested override shall be in accordance with 907 KAR 1:563.~~

(4) [~~Except for recipients under age twenty-one (21),~~] Prior authorization by the department shall be required for each service visit that exceeds the limit established in subsections (1) and (2) of this section for a recipient who is not enrolled with a managed

care organization.

[~~(5) The limits established in subsections (1) and (2) of this section shall not apply to a recipient under twenty-one (21) years of age.~~]

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving speech therapy from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for speech therapy provided to the same recipient during the same time period via the out-patient hospital services program.

Section 6. Records Maintenance, Protection, and Security. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 CFR 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 Chapter 164.

Section 7. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 8. Third Party Liability. A provider shall comply with KRS 205.622.

Section 9. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his responsibility in allowing the use of the electronic signature; and

(c) Provide the department with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature immediately upon request.

Section 10. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 11. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 12. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.(Recodified from 904 KAR 1:014, 5-6-86; Am. 17 Ky.R. 557; eff. 10-14-90; 33 Ky.R. 578; 1550; eff. 1-5-2007; 37 Ky.R. 984; eff. 11-05-2010; Recodified from 907 KAR 1:014, eff. 5-3-11.)

907 KAR 10:014

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

907 KAR 10:014

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 10:014
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding outpatient hospital services.
(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Medicaid Program coverage provisions and requirements regarding outpatient hospital services.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding outpatient hospital services.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding outpatient hospital services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The primary amendment sets a uniform limit [of twenty (20) physical therapy service visits or speech pathology service visits per recipient per calendar year] in lieu of the existing varied limits ranging from ten (10) to thirty (30) visits per recipient per month based on the benefit plan of the given recipient. The amendment preserves the existing option for recipients to receive services above the limits if additional services are medically necessary and prior authorized. Additional amendments include deleting references to the four (4) Medicaid benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years; establishing that the Department for Medicaid Services (DMS) will not reimburse for the same service provided to the same recipient by two (2) different providers at the same time; inserting records maintenance and relate confidentiality of medical records requirements; establishing that if third party liability exists for a given recipient that the provider is to bill the third party; establishing electronic signature requirements; and establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding; and inserting an appeals section for recipients regarding services being denied.
(b) The necessity of the amendment to this administrative regulation: Replacing the varying speech pathology service and physical therapy service limits with a uni-

form limit of twenty (20) service visits per recipient per calendar year is necessary to synchronize the Department for Medicaid Services' coverage of services with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid "expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are:

- The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option;
- The state employer health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- Secretary-approved coverage, which is a benefit plan that the secretary has determined to provider coverage appropriate to meet the needs of the population provided that coverage.

States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options.

Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy service limit of twenty (20) visits per recipient per calendar year, DMS is adopting the same limit.

Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.) Consequently, DMS is concurrently repealing the administrative regulation which establishes the four (4) benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years. The four (4) benefit plans vary little and DMS is establishing one (1) benefit plan for all Medicaid recipients including the new groups mandated or authorized by the Affordable Care Act. Additionally, there is an administrative and Medicaid Management Information System (MMIS) burden associated with preserving different plans as well as an administrative burden on providers and managed care organizations. Given that the plans vary little it is impractical if not inefficient to preserve the plans.

The no duplication of service amendment, the amendment requiring providers to comply with Medicaid program participation requirements established in 907 KAR 1:671 and 907 KAR 1:672, and the third party liability requirement is necessary to

maintain program integrity and prevent the misuse of taxpayer revenues. The electronic signature requirements are necessary to allow providers to use electronic signature and ensure that they comply with the requirements established for such in Kentucky law. Establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer revenues from being spent if no federal funding is provided. Establishing an appeals section for recipients is necessary to reinforce that recipients have appeals' rights regarding services being denied.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comporting with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by comporting with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Outpatient hospitals will be affected by the amendment as will Medicaid recipients who receive physical therapy services or speech pathology services via the outpatient hospital program. Currently, there are 106 hospitals located in Kentucky and participating in the Medicaid Program. Over 20,000 Medicaid recipients received physical therapy services via the outpatient hospital program in the most recently completed state fiscal year. Over 4,300 Medicaid recipients received speech pathology services via the outpatient hospital program in the most recently completed state fiscal year.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. No action is required of regulated entities or individuals.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed on regulated entities or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Outpatient hospitals will benefit from a simpler service limit structure as there will be one limit for all rather than variances due to four (4) different benefit plans.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS cannot accurately predict the future utilization of outpatient hospital services, but in the most recently completed state fiscal year DMS spent approx-

imately $77 million (state and federal funds combined) on outpatient hospital services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent almost $455.4 million (state and federal funds combined.) Of the nearly $77 million spent by DMS on outpatient hospital services, over $1.2 million (state and federal funds combined) was spent on physical therapy services; and over $596,000 was spent on speech pathology services. Of the almost $455.4 million spent by MCOs in aggregate on outpatient hospital services, almost $6.9 million was spent on physical therapy services and over $1.9 million was spent on speech pathology services.

(b) On a continuing basis: Please see the response to question (a).

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No fee nor funding increase is necessary to implement the administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The administrative regulation neither establishes nor increases any fee.

(9) Tiering: Is tiering applied? Tiering is not applied as the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 10:014
Agency Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.210 and 42 C.F.R. 440.220.

2. State compliance standards. KRS 205.520(3) states:

“Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. Medicaid programs are required to cover outpatient hospital services.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 10:014
Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? Some hospitals are owned by local government entities, but DMS is unable to accurately predict the impact of this amendment as revenues will depend on utilization of services. Given that more individuals will be eligible for Medicaid services (not as a result of the amendment to this administrative regulation though) utilization is expected to increase; thus, an increase in revenues is a logical expectation.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? Please see the response to question (b).
   (c) How much will it cost to administer this program for the first year? DMS cannot accurately predict the future utilization of outpatient hospital services, but in the most recently completed state fiscal year DMS spent approximately $77 million (state and federal funds combined) on outpatient hospital services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent almost $455.4 million (state and federal funds combined.) Of the nearly $77 million spent by DMS on outpatient hospital services, over $1.2 million (state and federal funds combined) was spent on physical therapy services; and over $596,000 was spent on speech pathology services. Of the almost $455.4 million spent by MCOs in aggregate on outpatient hospital services, almost $6.9 million was spent on physical therapy services and over $1.9 million was spent on speech pathology services.
   (d) How much will it cost to administer this program for subsequent years? Please see the response to question (c).

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____
Expenditures (+/-): ____
Other Explanation: